TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Aaron Ford, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-2921-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… this is a DD requested FCE"

Amount Sought: $581.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual relies on the above and all of the denial reasons noted on the EOBs and requests a resolution in its favor."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount Sought	Amount Due
January 07, 2016	Functional Capacity Evaluation (10 units)	$581.79	$532.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement for the service in dispute.
3. 28 Texas Administrative Code §127.10 sets out the procedures for designated doctors.
4. Texas Labor Code §408.0041 grants the Division of Workers' Compensation the authority to order designated doctor examinations.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 350 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal
   - 724 – No additional payment after a reconsideration of services.
   - 876 – Required documentation missing or illegible. See Rules 133.1; 133.210; 129.5; or 180.22
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code description/instructions.

Issues

1. Are Texas Mutual's documentation-based denials supported?
2. Is reimbursement due for the FCE in dispute?

Findings

1. Texas Mutual asserts other defenses on its explanation of benefits that involve the number of units billed. Texas Mutual contends that "Dr. Ford did not state the actual face-to-face time in his report." Texas Mutual further explains that when it examined **each test that was documented** as part of the FCE, the total time did not sufficiently support the 10 units billed. The applicable requirements for the billing and documentation of FCE pertinent to this type of denial are now considered.

   28 Texas Administrative Code §134.204, effective for dates of service from March 1, 2008 through August 31, 2016 is the rule that applies to FCEs. Specifically, Rule §134.204(b) and (g) contain the requirements for billing, and documentation of FCE as follows:

   - §134.204(g) requires health care providers to bill FCEs using CPT Code 97750 with modifier "FC."
   - §134.204 (b) (1) requires health care providers to bill their usual and customary charges using the most current Level I (CPT codes). According to American Medical Association (AMA) Current Procedural Terminology (CPT) Code 97750 FC is a timed code, billed in 15-min increments of direct (one-on-one) patient contact.
   - §134.204(g) requires that FCEs shall be reimbursed in accordance with §134.203(c) (1). Rule §134.203(c) (1) in turn states that health care providers **shall apply the Medicare payment policies** [emphasis added] with minimal modifications.
   - Applicable Medicare policy found at Medicare Claims Processing Manual 100-04, Chapter 5 titled *Part B Outpatient Rehabilitation,* Section 20.2-Reporting of Service Units describes the Medicare requirements for counting minutes for timed codes including 97750.
   - Section 20.2, paragraph C.-Counting Minutes for Timed Codes in 15 Minute Units states the amount of time for each specific intervention/modality provided to the patient **is not required to be documented** [emphasis added] in the Treatment Note. However, the total number of timed minutes must be documented.

   Review of the medical bill finds that Dr. Ford billed 10 units of code 97750 FC. Review of the FCE report finds a documented start time of 9:15am, and a documented end time of 12:05pm with a note "Duration: 2hrs

and 50min." The division finds that the documentation sufficiently supports that the total number of timed minutes resulted in 10 billable units of 97750 FC when compared to the requirements of Medicare Claims Processing Manual 100-04, Chapter 5, Section 20.2, paragraph C. Texas Mutual's contention that Dr. Ford was required to document each test performed as part of the FCE is not consistent with the applicable Medicare policy and therefore not supported. The division finds that 10 units of FCE are eligible for reimbursement.

3. According to 28 Texas Administrative Code §134.204 (d), the reimbursement for the service in dispute shall be the least of the Maximum Allowable Reimbursement (MAR) for 10 units of 97750 FC, compared to the amount billed by the provider for those 10 units of 97750 FC as follows:

CPT Code	MAR Rule §134.204(g) adopts 134.203(c)(1) MAR calculation by reference	Billed (from the medical bill provided)	Lesser of MAR and Billed Rule §134.204(d)
97750 FC	(56.82/35.8043) x $33.57 = $53.27 for one unit, then $53.27 x 10 units = $532.70 Total MAR	$581.79	$532.70

The total allowable for the service in dispute is $532.70. This amount is recommended for payment.

Conclusion

Dr. Ford has established that the amount he sought in this medical fee dispute due. As a result, the amount ordered is $532.70.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $532.70, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/16/16 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.